Supreme Court, U. S.
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No. 80-635

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

MICHAEL REESE PHYSICIANS AND SURGEONS, S.C., AND LAWRENCE FERGUSON, M.D.,

Petitioners,

v.

JEFFREY C. MILLER, DIRECTOR, ILLINOIS DEPARTMENT OF PUBLIC AID,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

STATE RESPONDENT'S BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether a participating state in administering its Medicaid program is required to recognize and compensate as a provider of qualified services a medical corporation consisting of physicians who provide quality treatment to indigent patients.

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The respondent, Jeffrey C. Miller,[1] Director of the Illinois Department of Public Aid respectfully requests that this Court deny the petition for a writ of certiorari seeking review of the court of appeal's opinion in this case.

[1] Arthur F. Quern resigned as the Director of the Illinois Department of Public Aid, effective September 1, 1979. Jeffrey C. Miller has been appointed as the Director of the Illinois Department of Public Aid. Supreme Court Rule 40.3 provides that under such circumstances Jeffrey C. Miller should be automatically substituted as a party.

OPINIONS BELOW

The *en banc* opinion of the court of appeals (Pet. App. 17a) is reported at 625 F.2d 764. The original panel opinion of the court of appeals (Pet. App. 7a) is reported at 606 F.2d 732. The memorandum order of the district court (Pet. App. 1a) is unreported.

JURISDICTION

The judgment of the court of appeals upon rehearing *en banc* was entered on July 18, 1980 and the petition was filed within 90 days thereafter. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATEMENT OF THE CASE

The Illinois Department of Public Aid (IDPA) is the state agency responsible for administering Illinois' participation in Title XIX of the Social Security Act, 42 U. S. C. § 1396a *et seq.*, commonly referred to as the Medicaid program. Prior to 1972, it was common practice throughout the country for state departments of public aid to reimburse medical providers participating in the Medicaid program at any address designated by the provider on the bill for services rendered. Quite frequently, such physicians had their payment vouchers sent directly to factoring companies which would pay the provider at a discounted amount of the face value of the bills in exchange for an assignment of the physician's interest in the bills. This enabled the provider to maintain a consistent cash flow and the factoring company to reap the profits over and above the percentage of the bill it paid to the provider. This system of payment, however, was found to be fraught with fraud and abuse. *See* H.R. Rep. No. 92-231, 92d Cong., 2d Sess. (1971), *reprinted in* [1972] U.S. CODE CONG. & ADMIN NEWS

4989, 5090. Prior to the submittal of bills, factors were able to alter and inflate the amount and types of services rendered without the knowledge of the providers. Providers had no opportunity to detect such fraud or abuse because payment was made directly to the factoring companies. Moreover, providers refused to take personal responsibility for ensuring that the bills submitted reflected charges for services actually rendered.

Such problems of fraud and abuse by those associated with the Medicaid program in Illinois are well documented. As the court noted in *Professional Factoring Service Assoc.* v. *Mathews,* 422 F. Supp. 250, 256 (S.D.N.Y. 1976):

> [I]n various memorandum and investigative reports [in files of the United States Department of Health, Education and Welfare] there were references to inflated and fabricated billings by factors, especially in Illinois, where reassignment of claims via powers of attorney was occurring on a large scale.

See SUBCOMM. ON LONG TERM CARE, SP. COMM. ON AGING, 94th CONG. 2D Sess., FRAUD AND ABUSE AMONG PRACTITIONERS IN THE MEDICAID PROGRAM, 1-3, 18-19, 45-48 (Comm. Print 1976). Motivated by such evidence of fraud and abuse, Congress enacted 42 U.S.C. § 1396a(a) (32) which requires in part that a state Medicaid plan must provide that no payments for services provided by a physician, dentist or other individual practitioner shall be made to anyone other than such individual.

In October, 1977, IDPA commenced the practice and policy of requiring each physician provider under the Medicaid program to designate one street address to which all payments for services to welfare recipients would be mailed. The use of postal lock boxes was not permitted. The rationale for this policy was to maintain stricter supervision over each recipient of Medicaid payments. In the past, corporate lock boxes had been rented by or placed under the control of factors. By requiring a

street address IDPA was better able to ascertain that payment vouchers were indeed mailed to the practicing physician. Moreover, by requiring the provider to designate one address to which all of his payments were to be sent, each physician could be held personally responsible for determining that he received payment only for services which he had actually rendered.

Petitioner, Michael Reese Physicians and Surgeons, S.C. was organized in December, 1972 for the express purpose of treating patients who come to Michael Reese Hospital without having previously chosen a physician. Prior to petitioner's inception, Medicaid patients at the hospital received treatment primarily from interns and resident physicians, rather than from experienced staff physicians. Over three hundred physicians devote a portion of their time to service at the clinic. As a condition of their employment, these employee-physicians are required to remit to petitioner all fees generated by their services to Medicaid recipients.

On October 6, 1977, petitioner filed this action challenging both IDPA's one address mailing policy and its practice of refusing to recognize medical corporations as physician providers under the Medicaid Act. The district court entered a preliminary injunction order which enjoined IDPA from sending Medicaid payments for services rendered by petitioner's employee-physicians to any address other than petitioner's designated corporate lock box. *See* Pet. App. 6a.

On appeal, the court of appeals reversed. (Pet. App. 7a-13a) The court first recognized Congress' concern with the effect that less reputable "Medicaid mills" had in contributing to escalating fraud in the Medicaid program. Noting the wide flexibility which Congress had vested in the states in the design of their individual Medicaid programs, the court observed that "Congress did not prevent state welfare departments from instituting other reforms which would fall within their discretion in administering the Medicaid programs." (Pet. App. 11a-12a) Moreover, in light of the Department of Health,

Education and Welfare's approval of Illinois' Medicaid plan, the court held that the agency's interpretation was entitled to substantial deference. (Pet. App. 12a) The court also rejected petitioner's claim that IDPA's practices violated the Due Process and Equal Protection Clauses of the United States Constitution, holding that IDPA's practices were reasonably related to combating the problems of Medicaid fraud and abuse. (Pet. App. 12a) In addition, the court recognized that the instant case presented a dispute between petitioner and its physician-employees rather than with IDPA. (Pet. App. 13a) Following rehearing *en banc,* a majority of the court of appeals adopted the original panel decision. (Pet. App. 17a-18a)

ARGUMENT

Petitioner extolls the "unique benefits" which medical corporations are able to offer the Medicaid patient and argues that unless this Court considers the statutory and constitutional questions presented in this petition for a writ of certiorari, it will be "forced to close shop." (Pet. 6-8) This "needlessly harsh result of banishing medical corporations from the Medicaid program", petitioner claims, provides ample reason for this Court to grant the writ of certiorari.

This argument fails to present any convincing reason why a writ of certiorari should be granted. This Court has set forth the various considerations which would enter into its determination to grant certiorari in a given case in Supreme Court Rule 17.1. There is absolutely no indication in that rule that the petitioner's continued economic survival is a factor which would in any way motivate this Court to exercise its jurisdiction.

Moreover, petitioner's argument fails to take into account the fact that any threat to its continued economic viability is not the direct result of IDPA's practices. As the court of appeals stated:

> [W]e note that this is basically a matter between the Michael Reese Corporation and its physician-employees. If the corporation can require its physicians to turn over all the fees they generate as employees to the clinic, it can also require them to list the clinic as their designated address with IDPA. If the corporation is not receiving payments from its employees, it is for one of two reasons: either the physicians are unable to administratively keep up with the services for which they are being paid, or they are willfully failing to turn over the payment vouchers. Both explanations reflect the reasons why IDPA instituted the new policy. Physicians were either unaware of the services being billed in their names, leading to inflated and fraudulent charges on the part of third parties, or else the physician-employees are failing to remit payment vouchers

> to Michael Reese for services performed at the clinic, then the corporation itself is in a much better position to police its employees than is the Illinois Department of Public Aid. (Pet. App. 13a) (footnote omitted)

As between these two postulated explanations, petitioner has admitted that the latter is, in fact, the case. As one of the dissenting judges noted below:

> As explained at the *en banc* oral argument, unless the payments are made to plaintiff corporation or at the very least to physicians at the corporation's address, *the physicians will receive payments at their own offices and may not remit any amounts to the corporate plaintiff.* The result will be that the corporate plaintiff will be forced to close shop. (Pet. App. 22a) (emphasis added)

As both the majority and the dissent realized, this case presents a dispute between petitioner and its physician-employees as to whether such employees will remit payments to petitioner for services performed in petitioner's clinic. IDPA's practices can only be characterized as causing indirect injury to petitioner as a result of the exercise of lawful power. While petitioner may have legal rights against its employees for their failure to remit their payments, the mere fact that they do not turn over such payments does not present an important issue of federal law that should be decided by this Court. *See O'Bannon* v. *Town Court Nursing Center,* ____ U.S. ____, 100 S. Ct. 2467, 2476-77 (1980).

II.

THE DECISION OF THE COURT OF APPEALS IS PLAINLY CORRECT.

The state respondent believes that a detailed argument on the merits of the federal statutory and constitutional issues is unnecessary, and that the opinion of the court of appeals as to the questions presented by petitioner is well reasoned and

correct. Since petitioner has urged, however, that Congress mandated that the states include medical corporations as physician-providers under the Medicaid program, a brief discussion of this argument is appropriate.

The majority decision of the court of appeals properly recognized that Medicaid is an experiment in cooperative federalism, allowing the states broad options in shaping the details of their program. (Pet. App. 11a) *See Harris* v. *McRae*, ____ U.S. ____, 100 S. Ct. 2671, 2683-85 (1980); *New York Dept. of Social Services* v. *Dublino*, 413 U.S. 405, 413 (1973); *King* v. *Smith*, 392 U.S. 309, 316 (1968). The court also recognized that Illinois' Medicaid plan, including the provision which limits participation and accountability to individual physicians, has been approved by the Department of Health, Education and Welfare as in compliance with the requirements of Title XIX of the Social Security Act and HEW's regulations. (Pet. App. 12a)

It is a well established principle of statutory construction that "[t]he interpretation of a statute by an agency charged with its enforcement is a substantial factor to be considered in construing the statute." *Youakim* v. *Miller*, 425 U.S. 231, 235-36 (1976). *Accord Johnson* v. *Robinson*, 415 U.S. 361, 367-68 (1974); *Udall* v. *Tallman*, 380 U.S. 1, 16 (1965). As long as the agency's interpretation is reasonable and there is no "compelling indications that it is wrong", the agency's construction should be given great deference. *Beal* v. *Doe*, 432 U.S. 438, 447 (1977); *New York State Dept. of Social Services* v. *Dublino, supra*, 413 U.S. at 405; *Red Lion Broadcasting Co.* v. *F.C.C.*, 395 U.S. 367, 381 (1969).

Congress, at the time it enacted the amendment to 42 U.S.C. 1396a(a)(32) banning the reassignment of claims and restating the state's option to mail payments either to individual physicians or their employers, recognized the problems which

the IDPA policies are designed to correct. The legislative history concerning the practice of assigning physicians' claims to other entities states that:

> Experience with this practice under these programs shows that some physicians and other persons providing services reassign their rights to other organizations or groups under conditions whereby the organization or group submits claims and receives payment in its own name. Such reassignments have been a source of incorrect and inflated claims for services and have created administrative problems with respect to determinations of reasonable charges and recovery of overpayments. H.R. REP. NO. 92-231, 92nd Cong., 2d Sess. (1971), *reprinted in* [1972] U.S. CODE CONG. & ADMIN. NEWS 4989, 5090.

It is just these problems that the one address rule and requirement that each individual physician bill and be responsible for services rendered to Medicaid recipients are designed to meet. The problems associated with allowing Illinois Medicaid providers to have their payments made to third parties are well documented. *See United States* v. *Ziperstein*, 601 F. 2d 281, 284-285 (7th Cir. 1979). The Department's requirement that each physician designate one office (or home) address at which he will receive Medicaid payments is the state's attempt to insure that physicians will be aware of just what services are being billed in their name. It is not unreasonable to assume that the abuses detailed in *Ziperstein* might not have occurred had such a rule been in effect at that time.

IDPA, as the agency charged with the administration of the Medicaid program in Illinois, has the necessary discretion under the Medicaid Act to impose its one address rule. Petitioner has failed to present any compelling reasons to show that there is a violation of either the purpose or intent of the Medicaid Act by IDPA's one address rule for physician payments.

Petitioner has also claimed that the court of appeals' opinion failed to consider whether IDPA violated the Medicaid Act freedom of choice provisions, 42 U.S.C. 1396a(a)(23), by refusing to recognize the corporation as a physician provider. This section provides that a state plan must provide that recipients may obtain medical assistance from any qualified individual or institution. HEW regulations interpreting 1396a(a)(23) pro- vide:

> **Free choice of providers.**
>
> (a) This section implements section 1902(a)(23) of the Act, which provides that recipients may obtain services from any qualified medicaid provider.
>
> (b) A State plan (except in Puerto Rico, the Virgin Islands, and Guam) must provide that any recipient may obtain medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis. . .
>
> (d) Paragraph (b) of this section does not prohibit the agency from—
>
> (1) Establishing the fees it will pay providers for medicaid services; or
>
> (2) Setting reasonable standards relating to the qualifications of providers. 42 C.F.R. § 431.51 (emphasis added)

IDPA has always restricted participation to *individual* physicians who provide the hands-on services to eligible recipients. (Pet.App.12a) Applicable provisions of the IDPA *Handbook for Physicians* provide that;

> A—201 *Physician Participation*
>
> A Doctor of Medicine (M.D.) or Osteopathy (D.O.) who holds a valid Illinois license to practice medicine in all its branches, is eligible for approval to participate in the Medical Assistance Program. . .

A—202.1 *Charges*

A physician may charge only for services he personally provides, or which are provided under his direct supervision in his office by his staff, e.g. laboratory services done by a technician in his employ.

A physician may not charge, however, for services provided by another physician even though one may be in the employ of another.

The federal Medicaid regulations define "physicians services" as services provided "[b]y or under the direct supervision of an individual licensed under state law to practice medicine or osteopathy." 42 C.F.R. 440.50(b).

The exclusion by IDPA of Michael Reese Corporation itself as a qualified provider of physicians services entitled to payment in its own name is within the state's discretion and clearly contemplated by both applicable federal and state regulations.

CONCLUSION

The petition for writ of certiorari should be denied.

Respectfully submitted,

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